



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Ultimate Pain Solutions

Respondent Name

City of Houston

MFDR Tracking Number

M4-17-3073-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

June 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Ultimate Pain Solutions believe that the claims listed below were underpaid and unpaid as Tristar Risk Management Insurance Company did not pay the (MAR) Maximum Allowable Reimbursement value."

Amount in Dispute: \$3,080.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the documentation no recommendation for payment is being made at this time. The requestor has provided no valid proof of submission per the 95 day billing rule time requirement."

Response Submitted by: Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 17 – 19, 2016	97110, 97035, 97140, 97110, 97035, 97140	\$510.00	\$0.00
October 21 - 24, 2016	97110, 97035, 97140, 97110, 97035, 97140	\$510.00	
October 26 – 28,2016	97110, 97035, 97140, 97110, 97035, 97140	\$510.00	
November 11, 2016	97110, 97140	\$260.00	
October 31, 2016 through November 2, 2016	97110,970325,97140,97110,97035,97140	\$510.00	
November 4 – 9, 2016	97110, 97140, 97100,97140, 97110, 97140	\$780.00	
	Total	\$3,080.00	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 148 – This procedure on this date was previously reviewed
 - 222 – Charge exceeds Fee Schedule allowance
 - 118 – Exact duplicate claim/service
 - 29 – The time limit for filing has expired.
 - P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. What is the timely filing deadline applicable to the medical bills for the disputed services?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “The time limit for filing has expired.”

28 Texas Administrative Code §133.20(b) requires that,

Except as provided in Labor Code §408.0272, a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Texas Labor Code §408.0272(b) provides certain exceptions to the 95-day time limit for bill submission:

Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

- (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
 - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
 - (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
 - (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than the 95th day following the date the disputed services were provided.

2. Texas Labor Code §408.027(a) states that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.”

28 Texas Administrative Code §102.4(h) provides that:

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,

- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds reports that indicate "claim created" and multiple dates. This documentation does not meet the requirements of Rule §102.4(h) to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	July 14, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.